# HIV/AIDS SITUATION AND PROGRAMME DEVELOPMENT IN THE COMMONWEALTH OF INDEPENDENT STATES



WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

## TARGET 5

## REDUCING COMMUNICABLE DISEASE

*By the year 2000 there should be no indigenous cases of poliomyelitis, diphtheria, neonatal tetanus, measles, mumps and congenital rubella in the Region and there should be a sustained and continuing reduction in the incidence and adverse consequences of other communicable diseases, notably HIV infection.*

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# ABSTRACT

Because the countries that emerged from the former USSR need to formulate their own programmes for the prevention and control of AIDS, the WHO Regional Office for Europe organized a consultation of the chiefs of the national AIDS programmes in the members of the Commonwealth of Independent States (CIS). The participants were asked to review the epidemiology of HIV in the countries, strengthen the countries' collaboration with one another and the WHO Global Programme on AIDS (GPA), and discuss the future development of the national AIDS programmes. The discussion revealed that, while the prevalence of HIV and AIDS in the CIS is low, the countries had inherited from the USSR a programme and facilities that stressed surveillance and care, not prevention. The participants discussed how to develop a multisectoral approach to AIDS prevention, which included the difficult problem of redeploying the available financial, material and human resources. Finally, the participants recommended that each country make a national plan for the prevention and control of HIV and AIDS as the prelude to a national programme, urged that such plans and programmes be multisectoral and nondiscriminatory, and asked WHO to support countries in this task as an adviser and advocate.

## *Keywords*

AIDS – prevent/control
HIV INFECTIONS – prevent/control
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# INTRODUCTION

Following the dissolution of the USSR at the end of 1991, members of the Commonwealth of Independent States (CIS) recognized the need to formulate their own AIDS control programmes in the new political climate, taking account of their cultures and traditions and the epidemiology of HIV infection in each country. The WHO Regional Office for Europe therefore organized a subregional consultation of the chiefs of national programmes for AIDS prevention and control of the members of the CIS. Programme managers from Estonia, Latvia and Lithuania were invited as observers. The participants were:

- to review the known epidemiology of HIV infection in the members of the CIS and the progress being made in the development of national AIDS programmes;
- to strengthen the countries' collaboration with one another and the Global Programme on AIDS (GPA) in the Regional Office; and
- to review priorities and identify urgent needs for the future development of the programmes for AIDS prevention and control.

Dr V.A. Glazovsky was Chairperson of the consultation, and Dr L.I. Mamedova and Dr P. Exon were the Rapporteurs. The participants are listed in Annex 1.

The consultation was opened by Dr V. Kazakov, Minister of Health of Belarus. Dr S.-E. Ekeid, Regional Coordinator of GPA, conveyed the greetings of the WHO Regional Director for Europe, and thanked the Ministry of Health of Belarus for organizing the meeting, as did Mr H. Dassanayake, of GPA at WHO headquarters.

# DISCUSSION

## Strategies and priorities of GPA

Three factors in the CIS increased the risk of HIV transmission:

- the changing attitudes to sex and sexuality;
- the increased use of illicit drugs and incidence of injecting; and
- the lack of technical equipment for health care (such as sterilization equipment and disposable equipment), which increases the danger of nosocomial infection.

CIS thus faced a serious, perhaps dangerous situation. Denial and complacency remained in some areas, and governments had to recognize that HIV threatened not just health but also economic recovery.

AIDS programmes should not be developed in isolation but as part of a general strengthening of public health services and the development of health promotion programmes. AIDS programmes can act as a vehicle for these changes, spreading their effects to other areas. To achieve such changes, the members of the CIS should reorient their health services and redefine their priorities. In particular, they should recognize that, while surveillance is important, it has never prevented the transmission of HIV. Some had spent 85 – 90% of their AIDS funds on surveillance, which cannot have been cost-effective.

On the global scale, sexual intercourse between men and women and between men accounted for 80% of the transmission of HIV. There was no reason to suppose that the experience of the CIS would be different. Prevention programmes needed to recognize that sexuality is a powerful force and that it is necessary to work closely with everyone who was sexually active, including homosexual and bisexual men. Equally important was the need to educate all children about sexuality and sexual health.

While transmission through injecting drug use was still comparatively rare in the CIS, it deserved attention. Belarus had been the first member of CIS to identify HIV-infected drug users. Coercive measures did not prevent such transmission. Countries should develop treatment and rehabilitation programmes to encourage existing drug users not to start injecting and to teach safe injecting practices to those unable to cease.

## The epidemiology of HIV

The problems and trends in assessing the epidemiology of HIV included the lack of data on its prevalence in all countries in the European Region. While the reporting of AIDS was standardized, there was little knowledge of the prevalence of asymptomatic infection. For example, while 500 seropositive people had been reported in the CIS, the number of people with HIV was estimated to be significantly greater.

Further, although the numbers of people with AIDS in central and eastern Europe were small, they had increased by 10% in the three months preceding the consultation and considerable delays in reporting remained. Excluding figures from Romania, however, infection via contaminated blood in these countries had begun to fall in 1987. Finally, the number of drug users with AIDS was now about equal to the number of homosexual men with AIDS.

All countries needed to conduct surveillance; knowledge of how HIV was being transmitted would help them to plan prevention and control programmes and to provide care and support for people with HIV.

## Activities in the USSR, 1987 – 1991

The USSR had concentrated on AIDS surveillance. From 1987 to 1991, huge populations had been tested at great expense. For example, following the identification of infected children at Elista,

2 million children had been tested and 12 million people (including blood donations) had been tested each quarter. It was calculated that during the period 1987 – 1991, 300 000 – 400 000 roubles (at the old currency rate) had been spent for each seropositive person identified. While this programme had been criticized, it had had some benefits, particularly the elimination of nosocomial transmission.

The USSR programme had included not only mass screening but also compulsory testing of contacts and compulsory notification of everyone found to be infected. Between 1987 and 1990, 110 centres for AIDS control were set up and it was agreed that their staff would receive a 60% supplement to their income.

The last law on AIDS in the USSR had been passed in 1990, to protect the human rights of people with HIV and to formulate policies for testing, including the screening of all pregnant women and those seeking termination. The law was still in force in the Russian Federation and a review was planned. The emphasis on extensive testing was expected to cease because of the heavy cost.

## Conditions in CIS and the Baltic states

Because the members of the CIS and the Baltic states had previously been republics of the USSR, there were many similarities in the epidemiology of HIV, the organization of AIDS prevention activities and inherited problems in each state.

The prevalence of HIV infection and AIDS was low. Many of the people infected were foreigners, but countries were beginning to ind infection in the indigenous population, usually in homosexual men and injecting drug users. Other common themes were:

- the existence of a network of AIDS prevention and care centres and testing laboratories developed and staffed before the dissolution of the USSR (Table 1);

- the lack of testing equipment in many of these laboratories, owing to the breakdown of old equipment and inability to pay for replacements;
- the desire to redirect AIDS programmes away from mass screening and towards prevention, diagnosis and care provision;
- the difficulty of convincing ministers for sectors outside health that AIDS was a serious problem for their society;
- the urgent need to educate and train health professionals about HIV infection and the issues that surround it;
- the existence of long-standing but counterproductive, coercive laws such as those proscribing homosexuality;
- the lack of knowledge about and information on AIDS in the general population, particularly in young people; and
- the lack of high-quality, affordable condoms.

Finally, only two countries (Estonia and Ukraine) had adopted a national plan for the prevention and control of HIV and AIDS; two others (Belarus and the Russian Federation) had submitted such plans to their parliaments for approval. The participants discussed these issues and the question of how best to develop a multisectoral approach to AIDS prevention.

## Developing a multisectoral programme for HIV and AIDS prevention and control

The participants discussed the merits of and problems with the network of specialized AIDS centres and laboratories inherited from the USSR. Some felt that this system should be maintained and could continue to be directed from Moscow. Most, however, felt that, while the members of the CIS needed to cooperate and to coordinate their activities, they should do so through mutual agreements, leaving each to develop its own prevention and control programme.

Some participants questioned the value of specialized centres where the prevalence of HIV infection was low and all areas of health care urgently needed strengthening. They acknowledged, however, that redirecting funds from such well developed programmes would cause problems, not least because many centres were fully staffed with AIDS specialists. A few participants felt that the programmes of widespread testing for HIV should continue, to identify infected people and define the true extent of the epidemic.

The participants noted important barriers to developing a multisectoral approach to AIDS prevention; the economic and societal problems in most members of the CIS, the widespread perception (particularly in doctors and health ministries) that AIDS was solely a health problem and the perception that other health care issues were more pressing. It was pointed out in response that many African countries had similar problems; because of the seriousness of the pandemic in Africa, they had come to recognize that a country needed a multisectoral, coordinated programme, headed by the prime minister, to control the spread of HIV.

At great cost, the USSR programme on AIDS prevention and control had demonstrated that the prevalence of HIV infection was low. Now that the scope of the problem was known, the countries of the former USSR needed to examine existing structures and to choose their priorities. Continuing to spend scarce resources on specialized AIDS centres and their staff seemed unreasonable when the epidemiological picture showed that there would be relatively few cases of AIDS in the next 6 – 10 years.

The existing programmes in CIS were not in line with the WHO global AIDS strategy. The resources available should be redeployed and spent on health education, health promotion and disease prevention. Such programmes would require health educators, psychologists and counsellors, who would in turn need training.

Table 1. The number of cases and existing facilities for HIV and AIDS in the former USSR

| Country | Number of people with | | Number and level of AIDS facilities | |
|---|---|---|---|---|
| | HIV | AIDS | Centres | Laboratories |
| Armenia | 1 | 1 | 1 national | 18 |
| Azerbaijan | 16 | 0 | 1 national | 28 |
| Belarus | 39 | 8 | 1 national<br>6 regional | 59 |
| Estonia | 22 | 1 | 1 national | - |
| Georgia | 5 | 2 | 1 national | 29 |
| Kazakhstan | 9 | 0 | 22 | 79 |
| Kyrgyzstan | 0 | 0 | > 5 | > 4 |
| Latvia | 20 | 2 | 1 national | 7 |
| Lithuania | 12 | 2 | 1 national | Several |
| Moldova | 4 | 2 | 1 national | Several<br>regional |
| Russian Federation | 559 | 94 | 6 regional<br>68 territorial | Numerous |
| Tajikistan | 2 | 0 | 1 | 23 |
| Turkmenistan | 0 | 0 | 5 | 45 |
| Ukraine | 102 | 12 | 1 national<br>5 regional | Numerous |
| Uzbekistan | 7 | 0 | 1 national | Several |

Further, the programmes should combat discrimination against people with HIV and AIDS. WHO stressed human rights and the avoidance of discrimination to protect not just the individual but also society. History showed that discrimination against people with sexually transmitted diseases drives them underground, to the detriment of public health.

As a rough guide, the global strategy of GPA suggested that less than 20% of the budget for AIDS control be spent on programme management, more than 45% on the prevention of sexually transmitted diseases (including the sexual transmission of HIV), a maximum of 15% on surveillance and a maximum of 15% on blood transfusion and laboratory services. For the CIS, it was suggested that a maximum of 10% be spent on clinical services, in contrast to the 66% currently spent on clinical staff that were caring for a small number of relatively well seropositive patients. Some countries of the former USSR had already begun to do this, as had some members of the CIS.

WHO could supply knowledge and expertise to assist countries in such work. WHO also had a role as advocate, and could help programme managers convince politicians:

- of the need to refocus programmes
- to address the difficult issues of discrimination and stigmatization
- of the need to educate the young about sexuality and sexual health
- of the importance of decriminalizing homosexuality and creating constructive and supportive programmes for drug users.

## AIDS surveillance and health promotion in the former USSR

Reporting on AIDS from the USSR had been coordinated through Moscow. Since the dissolution of the USSR, the WHO-European Community (EC) Collaborating Centre on AIDS in Paris had received very little information from the region.

The participants discussed the problems of collecting and communicating data to the centre, and its problems in communicating with the countries concerned. These countries

wished in future to communicate directly with Paris, and a meeting of experts to discuss the issue was urgently needed.

In the field of health promotion, governments needed to support programmes to promote sexual health by giving positive messages about the avoidance of discrimination against and stigmatization of people with HIV and AIDS. Cooperation between ministries for health and education was important.

AIDS prevention campaigns needed to employ three strategies:

- the provision of information to the public
- the empowerment of the individual
- participation by the community being targeted.

Successful health promotion must be carefully planned and its implementation monitored and evaluated. The question of cost-effectiveness must always be considered and it must be recognized that different target groups needed different approaches. People devising health promotion initiatives must avoid patronizing the target groups and inadvertently encouraging victim blaming, and should be realistic in planning, implementation and evaluation.

There was further discussion on how the medical specialists currently attached to AIDS centres could be redeployed. While some could take part in educating the public and health professionals, there was no easy solution to the problem and no single solution could be used in all countries. Each would have to find its own answers, depending on local circumstances.

# CONCLUSIONS AND RECOMMENDATIONS

1. All governments should recognize that the CIS is at a critical time in the prevention of the further spread of the HIV epidemic and thus that they should fund AIDS prevention programmes. This highlights the need for reorienting services for people with HIV and AIDS, redefining priorities, strengthening public health services and developing health promotion.

2. An effective programme for the prevention and control of HIV and AIDS may be used to activate the development and implementation of health for all approaches throughout the health and social services, and in other sectors of society.

3. A prerequisite for effective action and for the mobilization of resources is the formulation of a comprehensive, multisectoral national plan for HIV and AIDS prevention and control in each country. Endorsement by the political leadership of the country and the involvement of all sectors of government is essential for the acceptance and implementation of such a plan. In addition to mobilizing their own financial and human resources, many Member States will need financial, material and technical help from the international donor community to implement their national plans quickly and effectively.

4. WHO should assist the members of the CIS in developing their national plans, and ensure that technical assistance is available for their implementation.

5. The development process should lead to the making of long-term strategic plans and work plans for 1 – 2 years. Monitoring, evaluation and adjustment should be essential elements of the process.

6. A national plan should establish a national AIDS committee led by the prime minister or president; the committee members should include representatives of different ministries and disciplines, community leaders, opinion formers and representatives of nongovernmental organizations.

7. Involving and supporting nongovernmental organizations and the people affected by HIV and AIDS should be important elements of the development and implementation of prevention and control programmes.

8. Existing and planned legislation should be reviewed for its direct or indirect effects on the prevention and control of HIV and AIDS, and revised if necessary. Safeguarding human rights and the avoidance of discrimination and of stigmatization must be recognized as important elements in AIDS prevention. In addition, clinicians need education on the psychosocial aspects of HIV infection and the rights of patients to privacy and self-determination.

9. The integration of HIV and AIDS services in other health programmes (such as services for injecting drug users, sexually transmitted diseases, maternal and child health, and family planning services) should be encouraged.

10. Appropriate resources, designated for management and training, should be available to the managers of national programmes on HIV and AIDS. The costs and benefits of existing and planned measures should be assessed in the light of other priorities and the resources available. In particular, priority should be given to preventive activities rather than mass screening.

11. In view of the low prevalence or even the absence of clinical manifestations of HIV infection in some members of the CIS, the work of the available staff should be reorganized to focus on health promotion and disease prevention.

12. The mandatory testing of donated blood is justifiable to prevent the transmission of HIV through blood and blood products, but is otherwise unproductive as a means of controlling HIV transmission.

13. Early case detection through voluntary, confidential or anonymous testing is useful where proper measures, such as prophylactic treatment of opportunistic infection and supportive counselling of people with HIV, can be taken. Confidentiality is essential, regardless of the type of testing performed, to avoid driving people at risk underground.

14. WHO should give priority to supporting and assisting the members of the CIS in training trainers in the various aspects of the prevention and control of HIV and AIDS. Emphasis should be given to promoting health and preventing disease, particularly sexually transmitted disease and nosocomial infection. In particular, it is essential to recognize the importance of educating the young about human behaviour, relationships and sexuality before their first sexual encounter. Such education will take place largely in schools, but the needs of young people outside formal education systems should not be forgotten.

15. The countries should identify their training needs and communicate their requirements for assistance and support to WHO and other external sources of expertise.

16. Governments should recognize the importance of providing funding for their experts to attend international meetings.

17. In the field of testing, monitoring and surveillance, WHO should:

- assist the members of CIS to develop their monitoring, surveillance and reporting systems;
- with the WHO-EC Collaborating Centre on AIDS in Paris, assist countries to report AIDS cases directly to the centre, and to develop effective HIV surveillance systems;
- organize a workshop to review the coordination of data collection, sentinel surveillance and assessment of epidemiological trends, and to train a nucleus of epidemiologists in these tasks; and

- assist countries to develop their own confirmatory testing facilities and then monitoring and surveillance systems for diseases associated with HIV infection, such as sexually transmitted diseases, viral hepatitis and tuberculosis.

18. WHO should assist the development of nongovernmental organizations and AIDS service organizations the members of the CIS by encouraging and facilitating such organizations to form links with each other and with international nongovernmental organizations.

19. WHO should advise CIS members on the mobilization of resources from international organizations. On request, WHO should act as a broker when countries seek bilateral or multilateral donations.

20. The countries should strengthen the involvement of their ministers of health in the assessment of the overall government priorities and include health priorities in application for loans from the World Bank. On request, WHO will supply ministers of health with the arguments needed to advocate more involvement of the health sector in priority assessment.

21. WHO should organize a follow-up consultation to assess progress and development in the prevention and control of HIV and AIDS in the members of the CIS, and to evaluate the collaboration of GPA with national programmes in these countries.

*Annex I*

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